

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04393

## 4403 CERTIFICATE OF DEATH

Reg. Dist. No. 64

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE <b>Md.</b>		b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Federalsburg</b>		c. LENGTH OF STAY IN lb <b>full life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg, Md. R.F.D.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>		d. STREET ADDRESS <b>none</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Mary E. Adams</b>		First <b>Mary</b>	Middle <b>E.</b>	Last <b>Adams</b>	4. DATE OF DEATH <b>April 23, 1958</b>	Month <b>Apr.</b>	Day <b>23</b>	Year <b>1958</b>	
5. SEX <b>Fem.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 17, 1898</b>	9. AGE (In years last birthday) <b>59 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William J. Everngam</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Todd</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-0308660</b>		17. INFORMANT <b>Frank M. Adams</b>		Address <b>Federalsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>155.1</b>		Carcinoma of the Gall Bladder				INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO									
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Denton, Md.</b>		20f. (City or town) <b>Denton</b>		(County) <b>Caroline</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from Sept 21, 1943, to April 23, 1958, that I last saw the deceased alive on April 22, 1958, and that death occurred at 4:20 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Denton, Md.</b>			
ACTUAL SIGNATURE <i>E. Paul Knotts</i>		M.D.				DATE SIGNED <b>4/28/58</b>			
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/26/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Concord Cemetery</b>		22d. LOCATION (City, town, or county) <b>near Federalsburg, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James W. Williams</i>		ADDRESS <b>Federalsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE APR 28 '58		24b. REGISTRAR'S SIGNATURE <i>Al. Leach</i>			

## CERTIFICATE OF DEATH

BUREAU X.

APR 28 1959

RECEIVED

1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04394

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		4404 Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STATE Maryland b. COUNTY Caroline	
Rural Ridgely		10 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Rural Ridgely	
None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH Month Day Year
Male		Robert Col.	Bellamy	4	4 19 58
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 45 yrs.
Male		Col.		No record abour	IF UNDER 1YEAR Months Doy Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Farm Laboror		None		North Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Will Bellamy				U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Year, rank or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
Yes War 2		238-26-7808		William Dudley Maysville, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 928.8 DUE TO <i>Accidental drowning</i> Conditions, if any, which gave rise to immediate cause (b) DUE TO <i>Fell in River</i> (c) <i>Two minutes</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell in River</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 3:30 p. m. 4-4 1958		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>River</i> 20f. (City or town) (County) (State) <i>Rural Greensboro, Carter, Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Dawson O. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>4/10/58</i>	
EXAMINER'S NAME (Type) Dawson O. George		22b. DATE THEREOF <i>4/11/58</i> 22c. NAME OF CEMETERY OR CREMATORIAL UNION			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. LOCATION (City, town, or county) (State) <i>Goldsboro, Maryland</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaire &amp; Greenboro, Md.</i>		24a. REC'D BY REGISTRAR <i>Q. L. Johnson</i> 24b. REGISTRAR'S SIGNATURE			
VS. A15ME 5M 2/57		DATE APR 11 '58			

MISSOURI STATE EXAMINER'S CERTIFICATE OF DEATH

STATE  
MISSOURI

BUREAU V. S.

APR 11 1968

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04395

Reg. Dist. No.

1		4495										09X-2	
1. PLACE OF DEATH a. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		o. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Federalsburg		c. LENGTH OF STAY IN lb 5 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hurlock		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Preston Road											
3. NAME OF DECEASED (Type or print)		First William	Middle Francis	Last Carrow	4. DATE OF DEATH	Month April	Day 10	Year 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1900		9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Chief Rate Clerk		Service Trucking Co.		Princess Anne, Md.		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Margaret Reynolds											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WWI		16. SOCIAL SECURITY NO. 212-10-8943		17. INFORMANT Mrs. Mary F. Carrow, Hurlock, Maryland		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>													
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour 12:45 p.m.		Month, Day, Year 4-10 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Dawson O. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) Dawson O. George, M.D.		DATE SIGNED <i>4/14/58</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 13, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Memory Gardens		22d. LOCATION (City, town, or county) Hebron, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE APR 14 '58		24b. REGISTRAR'S SIGNATURE <i>Rebeleach</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WISCONSIN STATE BOARD OF HEALTH - DIVISION OF PUBLIC HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
APR 14 1928  
BURLAU V. S.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 44-6 CERTIFICATE OF DEATH

04396

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN 1b <b>4 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Tribbitt Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clara</b>		First <b>Josephine</b>	Middle <b>Denny</b>
4. DATE OF DEATH <b>4</b>		Month <b>10</b>	Day Year <b>1958</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>9/6/1880</b>	
9. AGE (In years last birthday) <b>77 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Denny</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Skinner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Harry Denny Wye Mills, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 10, 1956</b> , to <b>April 10, 1958</b> , that I last saw the deceased alive on <b>April 9, 1958</b> , and that death occurred at <b>11 P.M.</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b>			
DATE SIGNED <b>4/11/58</b>			
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b>			
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/13/58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Centerville</b>		22d. LOCATION (City, town, or county) (State) <b>Centerville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Bourlais Greensboro, Md.</b>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <b>APR 14 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Quebec</b>	

BUREAU Y  
RECEIVED  
APR 14 1958

WATERBURY STATE DEPARTMENT OF HEALTH - SATURDAY 10  
CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04397

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		44-17										2	
1. PLACE OF DEATH a. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE Maryland		b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Federalsburg, R.F.D.		Full Life		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Federalsburg, R. F. D.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)													
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First	Roland	Middle	Wright	Last	Hancock	4. DATE OF DEATH	Month April	Doy 9	Year 1958		
5. SEX		6. COLOR OR RACE	White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	Sept 9, 1899	9. AGE (In years last birthday)	58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Laborer		labourer		maryland		U. S. A.							
13. FATHER'S NAME		William D. Hancock		14. MOTHER'S MAIDEN NAME		Annie Wright							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No		220-03-3939		Mrs. Garfield Fleetwood,		Federalsburg							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Thrombosis Acute											
420.1		DUE TO		few minutes									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) DUE TO		2-40-									
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)													
Coronary Insufficiency													
20c. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Dawson D. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/10/58					
EXAMINER'S NAME (Type) Dawson O. George													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 12,		22c. NAME OF CEMETERY OR CREMATORIUM Concord Cemetery ADDRESS Md. Federalburg		22d. LOCATION (City, town, or county) Federalburg, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>James W. Williams</i>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Carl Smith</i>					

EXAMINER'S CERTIFICATE OF DEATH

STATE OF

BUREAU V. 2

APR 16 1988

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04398

## 4408 CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Caroline</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>		c. LENGTH OF STAY IN lb <b>25 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Denton</b>		d. STREET ADDRESS <b>Main St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Main St.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>NEVA</b>	Middle <b>A</b>	Last <b>JONES</b>	4. DATE OF DEATH <b>Apr. 12,</b>	Month <b>Apr.</b>	Day <b>12</b>	Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Dec. 15, 1889</b>	9. AGE (In years last birthday) <b>68</b>	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS. Days <b>8</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>George E. Robinson</b>				14. MOTHER'S MAIDEN NAME <b>Anne Willis</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Oliver Jones</b>		Address <b>Denton, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b>								
<i>420.1</i>		DUE TO  (b) <b>Coronary sclerosis and hypertension</b>				6 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO  (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> 20d. INJURY OCCURRED Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Denton</b>		(County) <b></b>	(State) <b></b>	
21. I certify that I attended the deceased from <b>April 15, 1952</b> , to <b>April 12, 1958</b> , that I last saw the deceased alive on <b>April 12, 1958</b> , and that death occurred at <b>4 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b>E. Paul Knotts</b> M.D.								
ACTUAL SIGNATURE								
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts</b>		Denton, Md.						
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 15, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Easton, Maryland</b> (State) <b></b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newham &amp; Son</b>		ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>Apr. 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. Deasey</b>		
VS A15 (4) 15M 9/55								

## CERTIFICATE OF DEATH

Burial # 5

APR 17 1959

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04399

4499

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland      b. COUNTY Caroline					
Caroline MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro	c. LENGTH OF STAY IN 1b 45 Yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		d. STREET ADDRESS None	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Agnes	Last Kibler				
4. DATE OF DEATH	Month 4	Day 6	Year 1958				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) New Jersey	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME James Carey	14. MOTHER'S MAIDEN NAME Elizabeth Rouke						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Margaret Carey	Address Greensboro, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Chronic Myocarditis	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic Bronchitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Greensboro	(County)	(State)		
21. I certify that I attended the deceased from Jan. 20, 1958, to April 6, 1958, that I last saw the deceased alive on April 5, 1958, and that death occurred at 10:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Charles H. Stonesifer, M.D. PHYSICIAN'S NAME (Type)						ADDRESS (Street, city or town, state) Greensboro, Maryland DATE SIGNED 4/9/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/10/58	22c. NAME OF CEMETERY OR CREMATORIAL Holy Cross	22d. LOCATION (City, town, or county) Greensboro, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.E. Boulaire, Greensboro, Md.	ADDRESS	24a. REC'D BY REGISTRAR APR 11 '58	24b. REGISTRAR'S SIGNATURE Webbouch				

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 11 1958

**REGELIA ED**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04400

4410

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		c. LENGTH OF STAY IN 1b <i>life</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>WILLIAM THOMAS LAYTON</i>		4. DATE OF DEATH <i>APR. 21 1958</i>	Month Day Year			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 7, 1888</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>AUTO</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>			
13. FATHER'S NAME <i>WILLIAM LAYTON</i>		14. MOTHER'S MAIDEN NAME <i>JASIE JONES</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. W. T. Layton, Denton, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs -</i>				
(b) DUE TO <i>Diabetes Mellitus</i>		<i>2 yrs -</i>				
(c) <i>Hangnail of feet -</i>		<i>6 mos -</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>260 X</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>12-4</i> , 19 <i>54</i> , to <i>4-21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>4-21</i> , 19 <i>58</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i></i>						
ACTUAL SIGNATURE <i>Dawson D George</i>		M.D.		DATE SIGNED <i></i>		
PHYSICIAN'S NAME (Type) <i>DAWSON D. George</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Apr 24 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>DENTON</i>	22d. LOCATION (City, town, or county) <i>DENTON, MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Johnson &amp; Son</i>		ADDRESS <i>Denton</i>	24a. REC'D BY REGISTRAR DATE APR 30 '58		24b. REGISTRAR'S SIGNATURE <i>Webb couch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

DEATH

CORONER'S

SURREAL M.

APR 30 1958

DECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04401

Reg. Dist. No.

1		4411			
FOR STATE HEALTH DEPT.		Caroline		MARYLAND	
1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro		c. LENGTH OF STAY IN lb 20 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print)		First Lawrence	Middle Earl	Last Roe	4. DATE OF DEATH 4 2 1958
5. SEX		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/9/1937	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Delaware	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME Katie Roe		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] Yes		16. SOCIAL SECURITY NO. 1955-57		17. INFORMANT Address Betty Kinnamon Goldsboro, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 810X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Internal injuries		INTERVAL BETWEEN ONSET AND DEATH few minutes few minutes	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) automobile was struck by RR train			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 4 - 2 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Goldsboro Caroline Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Dawson O. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4/2/58	
EXAMINER'S NAME (Type) Dawson O. George		22c. NAME OF CEMETERY OR CREMATORIUM Ridgely		22d. LOCATION (City, town, or county) (State) Ridgely, Maryland	
22e. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial 1 4/5/58		22f. REC'D BY REGISTRAR APR 7 '58		24b. REGISTRAR'S SIGNATURE <i>Dee Louch</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Boulaire Greensboro Md.</i>		ADDRESS			
VS. A15ME SM 2/57					

WISCONSIN STATE GOVERNMENT - DEPARTMENT OF  
WISCONSIN EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED BY

APR 7 1929

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #9 - Film G228 - 4/24/58-mb

4412

## CERTIFICATE OF DEATH

Reg. Dist. No.

04402

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<u>CAROLINE</u>		<u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>Denton</u>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>Denton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>101 Denton</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
		<u>LENA</u>	<u>STOKES</u>
4. DATE OF DEATH		Month	Day
		<u>APR</u>	<u>12</u>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
			B. DATE OF BIRTH <u>Dec 18, 1884</u>
8. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>DOMESTIC</u>		<u>HOME</u>	<u>MARYLAND</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>WILLIAM DRIVER</u>		<u>LETIE POTTERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
<u>No</u>		<u>-</u>	<u>Mrs. Lillie Baynard Jntor</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<u>Pneumonitis</u> 12 hrs	
492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.		(b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
General arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 19</u> , 19 <u>29</u> , to <u>April 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>April 11</u> , 19 <u>58</u> , and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <u>E. Paul Knotts</u>		DATE SIGNED <u>Denton, Md</u>	
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 15, 1958</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Spring Grove</u>
22d. LOCATION (City, town, or county) <u>Denton</u>		(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Knotts</u>		24a. REC'D BY REGISTRAR <u>John Knotts</u>	24b. REGISTRAR'S SIGNATURE <u>John Knotts</u>
		DATE <u>APR 21 '58</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OF FRONTIERS—ESTABLISHED THIRTY-NINE STATE CHARTERED  
BY THE UNITED STATES GOVERNMENT.

BUREAU Y.

APR 21 1958

REGIYED  
10-01-1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04403

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg rural</b>		c. LENGTH OF STAY IN 1b <b>full life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg rural</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last Alfred Allen Trice</b>		d. STREET ADDRESS <b>R.F.D.</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <b>July 7, 1908</b>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
10c. BIRTHPLACE (State or foreign country) <b>Choptank, Md.</b>		14. MOTHER'S MAIDEN NAME <b>unknown expired when young</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W. War 2 220-26-1335</b>	
17. INFORMANT <b>Mrs. Edith Trice Federalsburg, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
		<i>Carcinoma Stomach with General Metasis.</i>	
		INTERVAL BETWEEN ONSET AND DEATH <b>Jan 31- Apr 6 1958</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Federalsburg</b> (County) <b>Md.</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan 31</b> , 1958, to <b>Apr. 6</b> , 1958, that I last saw the deceased alive on <b>Apr 6</b> , 1958, and that death occurred at <b>100A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Federalsburg Md.</b> DATE SIGNED <b>W.E. Lennon M.D. Federalsburg Md.</b>	
ACTUAL SIGNATURE <b>W.E. Lennon</b>		PHYSICIAN'S NAME (Type) <b>W.E. Lennon M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/9/58</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Olivet Cemetery</b>		22d. LOCATION (City, town, or county) <b>St Michaels, Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Wilberson</b>		ADDRESS <b>Federalsburg, Md.</b>	
		24a. REC'D BY REGISTRAR DATE <b>APR 16 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81 ЗНОМІДЛЯ-ЖІЗНІ ІЗ ПІВНІЧНО-ЗАПАДОЮАУСТАМ

BUREAU V. 5

APR 16 1963

PEGEI V ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04404

## 4414 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb Rural Denton 2 yrs		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Denton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
LAWRENIA				WARREN	APR	9		19 58	
5. SEX	F	6. COLOR OR RACE	W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	MAR. 15, 1898		9. AGE (In years from birthday) 60 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
housewife		home		Maryland		U.S.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
PETE ANDREW		LONA N DCHOLS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				ERNEST WARREN, Federalburg Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		CEREBRAL HEMORRHAGE					2 mos		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Hypertension					?		
(b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>Apr 9</u> , 1958, to <u>Apr 9</u> , 1958, that I last saw the deceased alive on <u>Apr 9</u> , 1958, and that death occurred on <u>Apr 9</u> , 1958, from the causes and on the date stated above.							ADDRESS (Street, city or town, state)	DATE SIGNED	
ACTUAL SIGNATURE <u>H. L. Small</u>		M.D.					<u>Denton, Md.</u>	<u>Apr. 11-58</u>	
PHYSICIAN'S NAME (Type)		<u>H. L. SMALL, M.D. DENTON, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)	
Burial Apr 12, 1958				Bloomery		Near Smithville		Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
<u>J. H. Geiger mortuary Denton, Md.</u>				DATE		<u>W. J. Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

RECEIVED  
APR 14 1933  
FBI - MILWAUKEE

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1-and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg		c. LENGTH OF STAY IN lb 9 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) River Road		d. STREET ADDRESS River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James		Middle Wilson		4. DATE OF DEATH April 8		Month Year Day 19 58	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH About 1906	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Richmond, Virginia		9. AGE (In years last birthday) Labour 52	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 230-09-2948	
17. INFORMANT Mrs. Annie Hill, Federalsburg, Maryland		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>096.9</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Lobar Pneumonia</i> DUE TO cause last. (c) <i>Virus Infection</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>490X</i>		20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED <i>4/10/58</i>	
ACTUAL SIGNATURE <i>Dawson O. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		EXAMINER'S NAME (Type) Dawson O. George, M.D.			
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF April 11, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Federal Hill Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.J. Frampton and Son, Federalsburg, Maryland</i>		ADDRESS J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE APR 14 '58		24b. REGISTRAR'S SIGNATURE <i>Abraham</i>	

WISCONSIN STATE EXAMINER OF EDUCATION  
WISCONSIN EXAMINER OF DEIAN

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BUREAU X.  
APR 14 1958  
RECEIVED